Continuity of Care Request Form

NOTE: You may be able to still see your current doctor who is not a network provider to complete covered treatment or service. This is continuity of care. More information on continuity of care is in the California Health & Wellness Medi-Cal Member Handbook Combined Evidence of Coverage. **Please fill out this form to request continuity of care.**

Part 1: Member Information		
First and Last Name:	Medi-Cal ID#:	Date of Birth:
Address:	City:	Zip Code:
Phone Number:	Best Time to Call:	

Part 2: Provider Information – Information About the Provider You Want to Continue to See		
First and Last Name:		
Address:	City:	Zip Code:
What treatment or service(s) are you currently getting from this provider?		
Do you have an appointment scheduled with this provider? ☐ No ☐ Yes	If yes, what is the date of your next appointment?	

Part 3: Signature

Sign Here ➢ ______________________________ ______________________

Signature of Member or Authorized Representative — Date

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Print Name of Member or Authorized Representative

DIRECTIONS: Please fax this completed form to California Health & Wellness at (855) 556-7909 or mail it to California Health & Wellness Member Services, Continuity of Care Request, 1740 Creekside Oaks Drive, Suite 200, Sacramento, CA 95833. If you have questions about how to complete this form, please call California Health & Wellness Member Services Department, from 8 a.m. to 5 p.m. (PST), Monday through Friday, at **(877) 658-0305** (TDD/TTY 1-866-274-6083).